Chapter IV

THE EVOLUTION OF MBC's ENFORCEMENT PROGRAM

A. Introduction: Fulfilling the Promise of the Reform Act (MICRA)

To understand and improve the enforcement program of the Medical Board of California, it is necessary to understand the history of that program — why it was created, how it has been structured and funded, and how it has been carried out by those responsible for its implementation.

This chapter documents the history of MBC's enforcement program from its modern-day creation in 1975. This historical review focuses on five watershed legislative developments and the issues and events which brought them about. First and foremost was the pivotal reform legislation of AB 1 (Keene) in 1975,[32] the Medical Injury Compensation Reform Act ("MICRA" or "Reform Act"), which established the fundamental strategic plan for modern medical practice reform in California. Then in sequence this chapter reviews the highly significant legislative efforts that have followed the Reform Act: SB 2375 (Presley) in 1990,[33] SB 916 (Presley) in 1993,[34] SB 609 (Rosenthal) in 1995,[35] AB 103 (Figueroa),[36] and SB 1950 (Figueroa) in 2002.[37] Together, the Reform Act and the legislation that followed have shaped the purpose, structure, authority, and resources of the Medical Board's enforcement program.

Readers of this chapter will recognize that the "major problems of the day" in medical regulatory reform — including the problems that led to the 2002 creation of the Medical Board Enforcement Monitor — are not new. Rather, they are chronic and cyclical. They have been identified and analyzed on numerous occasions. Their solution has been attempted on numerous

[32] Cal.Stats.1975, 2nd Ex.Sess., c. 1.

[33] Cal.Stats.1990, c.1597.

[34] Cal.Stats.1993, c.1267.

[35] Cal.Stats.1995, c.708.

[36] Cal.Stats.1997, c.359.

[37] Cal.Stats.2002, c.1085.

occasions by the Board and the Legislature. And it is clear that these problems have not been adequately resolved. But as we will see, important progress has been made, and progress will continue if California rededicates itself to the public-spirited balance of reforms envisioned by the Reform Act of 1975.

This historical review[38] serves important goals in the cause of balanced medical regulatory reform that addresses the needs of all industry stakeholders. This chapter:

- Describes the seminal 1975 agreement underlying the Reform Act, which established the strategic plan for MBC's enforcement program, and then examines the extent to which all parties to that agreement have fulfilled their obligations under that strategic vision.

- Documents the evolution of the purpose of the Board's enforcement program — from one whose principal goal was to rehabilitate physicians to one whose "paramount priority" is public protection.

- Demonstrates the importance of proper and active legislative oversight of agency performance.

- Discusses numerous proposals made throughout the years to address the problems that still beset MBC today. Some of these proposals have been watered down in implementation, and often these have failed to resolve the problems. Other meritorious proposals have been rejected. We revisit these proposals and discuss their merits to enable today's policymakers to avoid reinventing the wheel.

- Charts the evolution of Board (and staff) attitudes and approaches toward their roles.[39] Prior to the 1990s, MBC was a narrowly composed and highly reactive board comprised mostly of physicians who were unaware of their responsibilities as government officials, uninterested in their public protection role, and concerned primarily with satisfying the wishes of the medical profession. Enforcement was not a priority, public (non-physician) input was not welcomed, and the Board was hostile toward anyone who tried to remind it of its role as a government agency dutybound to protect the public.

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[38] Much of this chronology is taken from the pages of the *California Regulatory Law Reporter*, published by the Center for Public Interest Law (CPIL) since 1980. In turn, the *Reporter* is based on Board and legislative documents (all of which are on file at CPIL), and CPIL attendance at and observation of Board meetings since 1980. The precise citations to the many reports and critiques contained in this chapter appear in Appendix B.

[39] The Monitor has attended almost all of MBC's quarterly meetings since August 1986.

Starting in about 1992, the Medical Board changed. With the appointment of new members, training sessions by the Wilson administration's Department of Consumer Affairs (DCA), and a sincere desire not to repeat the mistakes of its past, the Medical Board has emerged as a more proactive body, taking an interest in numerous issues affecting both the profession and the public. It has been and is now a diverse board blessed with talented and well-motivated members, both physician and public representatives, each of whom respects the input of others. The Board's members today demonstrate a clear commitment to their first duty as government officials to protect the public.

The historical overview below is facilitated by the basic structure of medical profession regulation: a multi-member board required by law to meet in public in order to make decisions. The resulting public participation in and scrutiny of discussions and decisions produces "government in the sunshine." This dynamic illuminates the agency's past performance and allows empirical measurement of efficacy.

In sum, this chapter will demonstrate the central theme of the MBC Enforcement Monitor's Initial Report: The 30-year history of events surrounding the Medical Board's enforcement program is the story of repeated promises of balanced medical regulatory reform — promises that have not yet been fully realized, and that the recommendations in this report endeavor to keep.

B. The Promise of Balanced Reform: MICRA and Its Effects

Prologue: The Board of Medical Examiners. Prior to 1975, the Medical Board was known as the Board of Medical Examiners (BME). It consisted of ten physicians and one non-physician "public member." Physician discipline was not a priority for BME; it largely delegated that responsibility to physician-dominated regional "medical quality review committees" (MQRCs), five-member panels empowered to hold medical disciplinary hearings and make recommendations to the Board. According to an August 1975 report of the Auditor General, BME licensed 72,000 physicians in 1974, of which 46,000 were actively practicing in California. During 1974, the Board took disciplinary action against 50 doctors, including 30 for narcotics/alcohol-related offenses; five for theft, bribery, embezzlement, and/or tax evasion; four for fraudulent billing; four for mental incompetence; three for sexual misconduct; and one — *one* — for incompetence and gross negligence. Only two of these 50 decisions were reached in less than one year; most of them took two to three years to complete.

BME's disciplinary track record — and its general failure to discipline incompetence and negligence — contrasted starkly with the incidence of medical negligence documented in a 1977 report jointly commissioned by the California Medical Association (CMA) and the California Hospital

Association (CHA).[40] That report estimated that, during 1974, at least 140,000 "potentially compensable events" occurred in California hospitals resulting from the adverse effects of treatments and procedures, incomplete diagnosis or treatment, or incomplete prevention or protection. Of these "events," CMA/CHA estimated that 20,000–27,000 were accompanied by evidence sufficient to establish tort liability under the standards of evidence applicable in 1974. According to a partial reporting of medical malpractice action results, the tort system yielded 141 judgments and settlements over $50,000 in 1974. Yet BME took one disciplinary action for incompetence and negligence.

AB 1 (Keene): The Medical Injury Compensation Reform Act of 1975. The above data indicate that in 1975 the post-damage tort system — with its attendant costs, delay, and incomplete coverage — was the principle mechanism for dealing with physician negligence. While theoretically responsible for removing incompetent and negligent physicians from the marketplace to protect the public (and thus mooting tort recompense), BME's performance was largely moribund. The result was predictable. In 1975, prior to effective state insurance rate regulation, malpractice insurers announced massive rate hikes, allegedly in order to pay jury verdicts and remain profitable. "Lucky" physicians were greeted with premium demands of two to five times the cost of their prior insurance; 2,000 unlucky physicians in southern California were told their coverage would not be renewed at any price. Outraged, the medical profession turned to the Legislature, demanding containment of the tort system's costs that (the doctors believed) caused these rate hikes, and threatening to practice without insurance or not practice at all. In a regrettable and still familiar dynamic, the doctors blamed the insurers, the insurers blamed the trial lawyers, and the trial lawyers blamed the doctors.

The result was the Medical Injury Compensation Reform Act (MICRA), enacted in AB 1 (Keene) during a 1975 special session. The Legislature found that "there is a major health care crisis in the State of California attributable to skyrocketing malpractice premium costs and resulting in a potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial of access for the economically marginal, and depletion of physicians such as to substantially worsen the quality of health care available to citizens of this state." According to then-Assemblymember Keene, the measure was deliberately designed to comprehensively address three issues — tort reform, medical quality control, and insurance regulation — that were of interest to the four sets of stakeholders "at the table" — physicians, lawyers, insurance companies, and patients. "A general policy . . . decision was made that all interested parties must sacrifice in order to reach a fair and rational solution to the insurance crisis . . . . AB 1 was drafted to include all reforms in order to prevent any one interest group from sabotaging any single-objective bill."[41]

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[40] California Medical Association and California Hospital Association, *Report on the Medical Insurance Feasibility Study* (1977).

[41] Assemblyman Barry Keene, *California's Malpractice Crisis*, in A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE (David G. Warren and Richard Merritt, eds. 1976) at 30.

In its tort reform provisions, AB 1 capped non-economic damages (such as pain and suffering) in medical malpractice actions at $250,000, a dramatic change. It also limited the contingency fee that plaintiff's counsel may charge in medical malpractice actions, provided (under the so-called "collateral source rule") that the jury in a medical malpractice action may be told of certain benefits payable to plaintiff (such as social security payments and benefits received under group health plans), and imposed a number of other disincentives to the filing of medical malpractice actions.

In exchange for these unprecedented concessions, the medical profession agreed to accept and support enhanced regulation of its ranks — with an emphasis on policing the quality of medical care provided and the removal of incompetent and negligent physicians from the marketplace.[42] According to Assemblymember Keene, "[h]ealth quality control provisions were essential to regain public confidence in the health care delivery system, and to assure that incompetent doctors are not allowed to practice and generate lawsuits."[43]

To implement health quality control, AB 1 abolished the Board of Medical Examiners and created a new "Board of Medical Quality Assurance" (BMQA) consisting of 19 members — twelve physicians and seven public members. BMQA was divided into three divisions: (1) a seven-member Division of Licensing (DOL) responsible for administering examinations, issuing physician licenses, and administering a new continuing education requirement aimed at eliminating "lifetime licensure" and ensuring "continuing competency" of physicians throughout their careers; (2) a seven-member Division of Medical Quality (DMQ) charged with overseeing the Board's enforcement staff, reviewing the quality of practice carried out by physicians, and making decisions in disciplinary matters; and (3) a five-member Division of Allied Health Professions (DAHP) responsible for overseeing the regulation of a number of non-physician "allied health licensing programs" (AHLPs) which were under the jurisdiction of the Board.

In addition, AB 1 established a "central file" mechanism to capture information on complaints and reports of misconduct against physicians, and set the stage for the transfer of investigative authority and the investigative function (in the person of professional investigators who would specialize in physician discipline matters) from the Department of Consumer Affairs to BMQA. It expanded the MQRC system and added public members to those local committees. AB 1 also added a number of so-called "mandatory reporting requirements" to assure that actions taken

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[42] According to Assemblymember Keene, "The California Medical Association (CMA) was willing to support AB 1, even though it was uncomfortable with the health quality reforms, because its members realized that tort reforms were essential to the future of medicine in California. (Indeed, the bill did contain all eight points that the CMA had sought in terms of tort reform)." *Id*. at 32.

[43] *Id*. at 30.

by other entities against potentially dangerous doctors are reported to the Board so that they might be investigated and appropriately disciplined. Business and Professions Code sections 801 and 802[44] required insurers and insureds to report to BMQA the payment of judgments, settlements, and arbitration awards in medical malpractice actions; section 803 required court clerks to report criminal charges and convictions against physicians to BMQA; and section 805 required hospitals and other health care institutions to report adverse "peer review" disciplinary action taken against the privileges of physicians to the Board.

Despite the number of reforms to BMQA's structure, AB 1 codified an unfortunate limitation on the Board's enforcement authority. The bill added new section 2372.1 to the Business and Professions Code, which directed DMQ and its MQRCs to "wherever possible take such action as is calculated to aid in the rehabilitation of a certificate holder or where due to lack of continuing education or other reasons restriction on scope of practice is indicated to order such restrictions as are indicated by the evidence. It is the intent of the Legislature that committees shall seek out those certificate holders who have demonstrated deficiencies in competency and then take such actions as are indicated, with priority given to those measures, including further education, restrictions on practice, or other means that will remove such deficiencies as are found from the evidence."

In 1976, BMQA considered a license fee increase to enable it to implement AB 1 (Keene). At that time, BMQA's license fee was $20 per year. At its January 9, 1976 meeting, DOL considered an emergency increase to $75 per year ($150 biennially). Over the objection of CMA, DOL approved the increase by a vote of 4–3. This fee increase enabled the transfer of investigators from the Department of Consumer Affairs to BMQA in 1977.

In 1980, the Legislature enacted a bill authorizing BMQA to create a "diversion program" for substance-abusing and mentally/physically ill physicians. Under this concept, physicians who abuse drugs and/or alcohol or who are mentally or physically ill may be "diverted" from the disciplinary track into a program that monitors their compliance with terms and conditions of a contract that is aimed at ensuring their recovery. Consistent with AB 1's "physician rehabilitation" goal, the Legislature stated its intent in section 2340 that BMQA "seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety." DMQ was expressly charged with establishing criteria for the acceptance, denial, or termination of physicians from the program and with responsibility for overseeing the functioning of the program.

[44] Unless otherwise noted, all further statutory references are to the California Business and Professions Code.

In August 1982, the Auditor General released a report on BMQA's enforcement and diversion programs. As to enforcement during 1981, the Auditor General documented 3,071 complaints received, 1,646 investigations conducted, 180 accusations filed, and 123 disciplinary actions taken (up from 50 in 1974). The Auditor General noted that BMQA's statute impeded it from exercising its disciplinary authority in at least three ways: (1) BMQA was authorized to discipline a physician's license only for "gross negligence" (an extreme departure from applicable standards) or incompetence ("lack of knowledge or ability in discharging professional medical obligations"), whereas an additional 1,285 cases were "closed with merit" because a medical expert was unwilling to testify that the conduct involved was more than "simple negligence," (2) BMQA — unlike other state and federal agencies — was "limited in its access to patient records while investigating cases," and (3) BMQA could not require physicians to take competency examinations.

As to the Diversion Program, the Auditor General criticized DMQ for failing to establish any formal policies governing surveillance of participant compliance with the terms and conditions of their contracts. Specifically, the Auditor General found wide variability in the frequency of Program staff's contacts with participants, inadequate monitoring of participant compliance with specific terms of their contracts, inadequate verification of participant attendance at required support group meetings, failure to ensure that treating psychotherapist reports were submitted to the Program, and failure to ensure that participants obtained "worksite monitors" to oversee their medical practice. Additionally, the Auditor General criticized the Diversion Program for inadequate recordkeeping (noting that "records on each participant are scattered among three separate files" across the state) and for failure to terminate participants who do not comply with the terms of their contract; this latter deficiency was attributed to DMQ's failure to establish clear standards and guidelines for terminating participants. In 1985 and 1986, the Auditor General issued two more reports on BMQA's Diversion Program; these reports are reviewed in Chapter XV.

In July 1988, the Assembly Office of Research (AOR) issued a report entitled *No Such Listing: Consumer Access to the Board of Medical Quality Assurance*. In this study, AOR surveyed all telephone books available to the public in the State Capitol and State Library. Of 63 phone books examined, only 11 contained a phone number for BMQA. AOR contacted Pacific Bell, which at that time distributed directories to 90% of California calling areas. As of June 1988, BMQA appeared in only 33 of 172 directories. Finally, test calls to information operators seeking BMQA's number revealed the response that "no such listing exists" even though the caller identified BMQA as a state agency. AOR found that BMQA's public outreach efforts were "minimal," and suggested that BMQA attempt to achieve its stated 1987 goal of establishing a toll-free consumer information number.

In late 1988, a large backlog of complaints began to accumulate at BMQA, causing consumer complainants to contact their legislators and attracting the attention of the Legislature and the

Legislative Analyst's Office (LAO). At DMQ's December 1988 meeting, the Board's enforcement chief announced that almost 800 complaints — 80% of which involved "a potential for patient harm or needing additional information before a case disposition decision could be made" — were backlogged and unassigned to BMQA investigators. About 65% of the cases with a potential for patient harm had been unassigned for a minimum of three to six months. In response, DMQ adopted a "prioritization" policy under which complaints involving actual or high potential for patient harm were to be given top priority by BMQA investigators, who had — according to the enforcement chief — two to three times the caseloads of any state agency investigating consumer complaints. In early 1989, BMQA increased its renewal fee to $145 ($290 biennially), but only to maintain the reserve fund required by law and not to add investigators, create a toll-free complaint line, or implement public education programs about BMQA's existence and enforcement program.

In February 1989, LAO released its review of BMQA's proposed 1989–90 budget, and documented the unassigned case backlog of 800 cases. Finding that a majority of the backlogged cases "may have a potential for physical harm to the public" which is "undesirable and inconsistent with the Board's stated mission," LAO noted that BMQA had failed to request any additional staff to handle the backlog and required BMQA to report to the Legislature on "how it plans to address the projected number of unassigned cases in 1989–90." The 1989–90 Budget Bill required the Board to file quarterly reports with the Joint Legislative Budget Committee detailing the status of the backlog.

Also in February 1989, the Little Hoover Commission released its third report in six years condemning the quality of medical care provided by the state's nursing homes for the elderly. The Commission found that "many of the 115,000 persons who are spending their final days in California's nursing homes face poor medical care — or none at all — and there is no one in charge of protecting them." Along with the Department of Health Services' Licensing and Certification Division, the Commission singled out BMQA for criticism, finding that BMQA had been "singularly inactive in this area, having neither adopted standards of care for nursing homes nor instituted a citation and fine system for those who fail to provide adequate care."

Code Blue. In April 1989, the Center for Public Interest Law (CPIL) released a report entitled *Physician Discipline in California: A Code Blue Emergency*. Based on a three-year investigation, *Code Blue* presented evidence indicating the minimal output, fragmented structure, and questionable priorities of BMQA's enforcement program.

First, *Code Blue* revealed that BMQA's enforcement performance — despite multiple fee increases, the infusion of information about physician misconduct from a variety of sources, and MICRA's promise of a strengthened physician discipline system — had actually declined since the Auditor General's 1982 report. During 1987–88, BMQA received 4,685 complaints, opened 1,900 investigations, filed 109 accusations, and took 92 disciplinary actions. During that same year,

BMQA was notified that 715 physicians suffered medical malpractice judgments or settlements in excess of $30,000, and 249 physicians had been the subject of adverse peer review action by hospitals. Of BMQA's 92 disciplinary actions, exactly twelve (12) were for negligence or incompetence; the vast majority of BMQA's disciplinary actions "piggybacked" off criminal convictions or disciplinary actions taken by another state medical board.

CPIL noted that, in a regulatory setting where delay can cause irreparable harm and cost lives, the highly fragmented physician discipline process administered by BMQA, its 14 MQRCs, its eight regional offices, and its "enforcement partners" over whom BMQA has no control — including the Licensing Section within the Attorney General's Office (whose generalist prosecutors filed charges and tried disciplinary matters against physicians, pharmacists, contractors, accountants, and numerous other DCA licensees), the Office of Administrative Hearings (whose administrative law judges (ALJs) preside over evidentiary hearings in physician discipline matters and make recommendations to DMQ), and the judicial system (which reviews DMQ disciplinary decisions and entertains motions for temporary restraining orders (TROs) to stop practice in appropriate cases) — frequently required *six to eight years* to reach a result. In 99% of those cases, the accused physician continued to practice during that entire period. During 1987–88, BMQA sought no TROs to suspend practice pending the conclusion of the long disciplinary process; it had sought only three TROs since 1985–86. Neither BMQA nor any of its enforcement partners kept systematic records of the throughput or output of the enforcement program — inhibiting informed, data-based enforcement policymaking by either the Board or the Legislature. Further, BMQA disclosed almost no information about dangerous licensees to the public. Although it received many reports of criminal convictions and civil judgments against doctors (all of which is public information), BMQA refused to disclose any of that information to consumers seeking it; it disclosed only its own disciplinary actions, which were few and far between.

In *Code Blue*, CPIL argued that the heart of the problem lay in the fact that BMQA investigators — who lack a law school education and are supervised by management who were responsive to the politically-appointed physician majority on the Board — were investigating complex cases with no legal guidance whatsoever. BMQA investigators were "handing off" an investigation report to a prosecutor who was unable to specialize in medical disciplinary matters and was often unfamiliar with BMQA's statute and regulations, had no input into the investigation, and was without investigative assistance after receiving the case. CPIL contended that the number and complexity of BMQA disciplinary matters justified the creation of a unit of prosecutors in the Attorney General's Office to specialize in medical discipline cases, and that BMQA's investigators should be transferred to that unit to effectuate a "vertical prosecution model" similar to that used by other law enforcement agencies investigating and prosecuting complex white-collar crime cases — investigators and prosecutors working together on cases from the day they are referred for investigation.

Similarly, CPIL proposed the creation of a special panel of ALJs within the Office of Administrative Hearings, to enable them to specialize in physician discipline proceedings. *Code Blue* argued that these ALJs — as an alternative to superior courts — should be empowered to issue "interim suspension orders" in egregious cases, and to grant remedies short of license suspension, including practice restrictions and required testing. CPIL also called for a streamlining of BMQA's disciplinary decisionmaking process and its judicial review. *Code Blue* questioned the value of DMQ review of proposed ALJ decisions, inasmuch as DMQ members are not present at the hearing, do not have access to the transcript of the hearing or the evidence presented, and generally have no knowledge of the rules of evidence or the specific specialty at issue. CPIL argued that the OAH ALJ should make the final agency decision (based on disciplinary guidelines fashioned by DMQ), subject to a petition from either party which would be submitted to a special panel of the Court of Appeal (thus eliminating superior court review of DMQ disciplinary decisions).

Code Blue also proposed a number of other reforms — including the creation of a toll-free line whereby consumers could inquire about the disciplinary histories of their physicians; the required disclosure of information concerning criminal arrests and convictions, civil malpractice actions, hospital disciplinary actions, prior disciplinary actions by BMQA or other state medical boards, and pending high-priority investigations (with appropriate disclaimers); expanded reporting requirements to ensure the Board learns of problem physicians; enactment of a "cost recovery" mechanism enabling BMQA to recoup some of its investigative costs from disciplined licensees; imposition of a case cycle "goal" requiring investigators to complete most investigations within six months; and a requirement that BMQA report significantly more detailed annual enforcement data to the Legislature. Finally, CPIL proposed that the Medical Practice Act be amended to elevate public protection above "physician rehabilitation" in DMQ's priority hierarchy.

In May 1989, Senator Robert Presley introduced SB 1434 (Presley) to implement the recommendations in *Code Blue*. At its May 1989 meeting, BMQA — opposed to SB 1434 and arguing that all it needed was additional staff — defended itself by noting that between 1983–84 and 1988–89, it had requested an additional 33.5 enforcement positions but had only been granted 3.5 permanent positions and three additional limited-term positions. The Board also agreed to increase its renewal fees to at least $360 biennially, and to support then-pending legislation increasing its fee ceiling to $400 biennially.

In July 1989, in hopes of fending off SB 1434 and decreasing the backlog that was attracting legislative attention, BMQA agreed to increase its enforcement staff by adding 18 permanent investigator positions and 10 additional limited-term enforcement positions, and to create a toll-free complaint line. However, it refused to approve any other changes to the structure of its enforcement program. Due to CMA and BMQA opposition, SB 1434 became a two-year bill.

The Board did agree to one change, however. In September 1989, AB 184 (Speier) was enacted by the Legislature and signed by the Governor. This Board-sponsored bill removed the "medical quality" concept from the Board's name and renamed BMQA as the Medical Board of California (MBC). SB 1330 (Presley) also passed in 1989, increasing MBC's biennial fee ceiling to $400. However, MBC kept its renewal fee at $360.

At a December 1989 meeting, DMQ conducted a special review of its discipline program, and concluded that many of its weaknesses were due to factors that were beyond its control. For example, long delays in investigations were attributable to inadequate salaries for MBC investigators and constant turnover in those positions. During investigations, physicians and health care facilities often balked at producing medical records, further contributing to the delay. The Attorney General's Office and the Office of Administrative Hearings, which are required participants in MBC's enforcement program, were completely outside MBC's control. Finally, many MBC disciplinary cases boiled down to "a battle of the experts," and accused physicians are often able to produce higher-paid and better qualified experts, resulting in decisions favorable to the respondent physician. Although it resolved to address as many of these problems as possible, DMQ essentially absolved itself from responsibility for many of the problems documented in the LAO and CPIL reports.

In January 1990, despite significant media coverage of *Code Blue* and newspaper editorials strongly supporting MBC structural reform, Senator Presley was forced to withdraw SB 1434 due to CMA and MBC opposition.

C. The Perfect Storm: SB 2375 (Presley) and Its Effects

The Perfect Storm. During early 1990, a "perfect storm" of events combined to result in the eventual passage of SB 2375 (Presley), the first major MBC structural reform bill since AB 1 (Keene) in 1975.

On February 5, 1990, Los Angeles Superior Court Judge Judith Chirlin sentenced Dr. Milos Klvana to 53 years to life in prison following his December 1989 conviction on 47 felony counts, including nine counts of second-degree murder. Klvana, who was previously convicted on 26 counts of illegal prescribing in 1978 but only placed on probation by MBC, was found responsible for the deaths of nine infants between 1982 and 1986. After a ten-month trial that was widely publicized in the *Los Angeles Times*, the jury found that Klvana — who operated a birthing clinic in a low-income area of Los Angeles — had overdosed their mothers on Pitocin, a labor-inducing drug. MBC investigated four of those deaths, but allowed Klvana to continue practicing due to "lack of sufficient evidence." Despite its investigations and the facts that a February 1984 memo from one of MBC's own medical consultants concluded that Klvana had committed gross negligence and had been the subject of a $1 million medical malpractice judgment in 1986, MBC took no action to restrict Klvana

from practicing until March 1988 — well after Klvana had been arrested and jailed. In sentencing Klvana on February 5, Judge Chirlin did not restrict her harsh comments to the defendant. She cited the "abject failure" of the Medical Board, and stated that MBC "must share in the blame and accept responsibility for at least some of the deaths in this case." After detailing the Board's conduct in the case, Judge Chirlin asked: "And this is the board we have to protect us against unscrupulous and incompetent doctors? How many more dead babies or dead patients of other incompetent doctors will it take before the Board . . . is forced to take a serious and in-depth look at its procedures?" Noting DMQ's December 1989 self-examination of its disciplinary program, Judge Chirlin expressed outrage at the Board's internal investigation and stated that "the Board did an even worse job investigating itself than it did in investigating Dr. Klvana."

Within a week, Senator Presley introduced SB 2375 (Presley), a reintroduction of SB 1434 which he had withdrawn only one month earlier. Accompanying Senator Presley at the press conference announcing the bill's introduction were Judge Chirlin, Los Angeles Deputy District Attorney Brian Kelberg (who prosecuted Klvana), and Klvana jury foreman Jaime Pulido. Senator Presley vowed passage of the bill to "fill the holes in MBC's physician discipline process that had allowed Klvana to victimize the public for a ten-year period."

Also in February 1990, LAO released a new report documenting an increase in the number of backlogged cases unassigned to investigators to at least 870. LAO also noted that only seven of the 18 newly authorized investigator positions had been filled, and opined that "the Board's effectiveness in protecting the public is questionable." In a March 1990 letter to the legislature, MBC admitted that the backlog had soared to 914 cases in December 1989, but had dropped to about 600 cases by March 1990; MBC offered no explanation for the sudden drop. In the 1990–91 budget bill, the Legislature allocated only one-half of MBC's annual budget, and notified the Board that it would receive the other half only if it reduced its backlog of unassigned cases. In response, Board management ordered the unassigned cases to be assigned to investigators.

Meanwhile, in May 1990, the *Los Angeles Times* published a two-day follow-up series to the Klvana prosecution, which focused on MBC's "lagging" disciplinary performance and CMA's "powerful" influence in the Legislature ("doctors' lobby uses clout to block agency reforms"). Lengthy stories in the *Los Angeles Daily News* and on the CBS television affiliate in Los Angeles offered similar critiques.

In June 1990, the U.S. Department of Health and Human Services released a draft report announcing that California ranked near the bottom of the nation in physician discipline. During 1987, California was 42nd among the states in the number of serious disciplinary actions taken against physicians. The report noted that California has "relied particularly heavily" on private "nondisciplinary" actions against physicians, such as warning letters, educational conferences, and

its diversion program for physicians who abuse drugs and alcohol. DHHS found that other states "have discontinued the use of such private approaches," citing "public suspicions of boards being too understanding or lenient toward physicians."

These events — and the statewide publicity that accompanied them — stimulated strong public and legislative support for MBC structural reform. After four sets of amendments to SB 2375 (Presley), CMA agreed to take a neutral position on the bill in June 1990. After many objections and further amendments to the bill, MBC finally agreed to support the bill in the legislative session's last days. In September 1990, Governor Deukmejian signed the landmark bill (Chapter 1597, Statutes of 1990).

SB 2375 (Presley). "Presley I" — also known as the Medical Judicial Procedure Improvement Act — was a 39-part bill that made a number of significant changes to the physician discipline system implemented by MBC and its enforcement partners. In SB 2375, the Legislature declared that "the physician discipline system administered by the board's Division of Medical Quality is inadequate to protect the health, safety, and welfare of the people of California against incompetent or impaired physicians. It is, therefore, the intent of the Legislature to restructure the physician discipline system of the Medical Board of California . . . ."[45]

Although SB 2375 did not include *Code Blue*'s proposed streamlining of the decisionmaking process, it included the following important reforms:

- The bill enacted Government Code section 12529 *et seq*. to create a new Health Quality Enforcement (HQE) Section in the Attorney General's Office. Carved from the Licensing Section, HQE prosecutors specialize in medical disciplinary matters and related cases generated by the allied health licensing programs. SB 2375 did not transfer MBC's investigators to the Attorney General's Office as proposed in *Code Blue*. However, the statute expressly required the HQE chief to "assign attorneys to assist [DMQ] in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit . . . , to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations."

[45] The Legislative findings included: "It is, therefore, the intent of the Legislature to restructure the physician discipline system of the Medical Board of California in order to give it authority to act quickly in extreme cases to impose interim protective measures or final sanctions short of license revocation or suspension; more information from a variety of enhanced reporting sources and increased public outreach; procedures which afford a fair review and hearing by an experienced administrative law judge without excessive delay; procedures to ensure a high quality hearing; and enhanced resources to finance such a system in the interests of protecting the people of California. It is therefore the intent of the Legislature to improve the discipline system of licensed physicians and allied health professionals by creating a more expeditious and efficient adjudicatory system and providing it the adequate resources for its performance. It is also the intent of the Legislature that the pay scales for investigators of the Medical Board of California be equivalent to the pay scales for special investigative agents of the Department of Justice, in order to attract and retain experienced investigators." SB 2375 (Presley), Cal.Stats.1990, c.1597.

■ Similarly, SB 2375 enacted Government Code section 11371 to create the Medical Quality Hearing Panel, a specialized panel of ALJs within the Office of Administrative Hearings to hear medical discipline cases. The bill requires the MQHP ALJs to "have medical training as recommended by the Division of Medical Quality and approved by the Director of the Office of Administrative Hearings." To assist the panel ALJs in piercing "hired-gun" expert testimony, the law also requires DMQ to make "panels of experts" available to the MQHP ALJs, and permits them to call one of the panel members as an expert witness in a Medical Board evidentiary hearing (on the record and subject to examination by both sides).

■ SB 2375 also added section 11529 to the Government Code, which authorizes DMQ to seek and OAH ALJs to issue "interim suspension orders" (ISOs) to immediately halt the practice of very dangerous physicians in egregious cases. This alternative to the civil court TRO process was unique to MBC in 1990, but was soon replicated for most DCA agencies.

■ Although the bill failed to enact *Code Blue*'s proposals to eliminate DMQ review of the ALJ's decision and superior court review of DMQ's decision, it added new section 2337 which provided for fast-track judicial review of DMQ disciplinary decisions.

■ The bill enhanced required reporting to the Board on physician negligence and misconduct. For example, SB 2375 added section 802.5 to the Business and Professions Code to require coroners to file a report with MBC when they suspect that a physician's gross negligence is a cause of death. The bill added sections 803.5 and 803.6 to require local prosecutors to report to MBC the filing of felony charges against physicians, court clerks to transmit conviction records and preliminary hearing transcripts to MBC, and probation officers to transmit certain probation reports on physicians to MBC. Although the bill enhanced the flow of information into MBC, it did not impose any new public disclosure requirements on the Board — as had been recommended in *Code Blue*.

■ SB 2375 amended section 805 to increase the maximum penalty against hospitals and HMOs that fail to comply with the peer review reporting requirements in that section.

■ The bill added section 2313, which requires MBC to compile and report certain disciplinary information to the Legislature and the public in its annual report every year. This "accountability provision" enables the Board, the Legislature, and the public to compare year-to-year statistics and discern time delays and backlogs.

■ SB 2375 added section 2319, which required DMQ to establish a goal — by January 1, 1992 — of allowing no more than six months to elapse from receipt of a complaint to completion of the investigation. For cases involving "complex medical or fraud issues or complex business or

financial arrangements," the goal is one year from receipt of the complaint to completion of the investigation.

■ The bill also amended section 2307 to lengthen the time (in most cases) between revocation and the filing of a petition for reinstatement from one to three years.

■ SB 2375 amended Civil Code section 43.8 to provide absolute immunity from civil liability for physicians who serve as expert reviewers and expert witnesses in MBC disciplinary matters.

■ Finally, and perhaps most important, SB 2375 amended section 2229 to shift DMQ's primary priority from physician rehabilitation to public protection. As amended by SB 2375, section 2229 provides that "[p]rotection of the public shall be the highest priority for the Division of Medical Quality . . . in exercising [its] disciplinary authority." The provision recognizes physician rehabilitation as a goal, but expressly states that "[w]here rehabilitation and protection are inconsistent, protection shall be paramount."

In 1991, the Attorney General's Office created the new Health Quality Enforcement Section. The new HQE chief reported to DMQ at its February 1991 meeting that the section consisted of 22 deputies, and had set a goal of filing an accusation within 60 days of its receipt of a completed investigation. In May 1991, however, HQE announced that it was severely understaffed due to a "clerical error" in determining the appropriate number of attorneys to staff the section. Fully investigated cases began to accumulate at HQE, and the unit was taking almost seven months to file an accusation in a fully investigated case. Because of the staffing crisis, HQE and MBC did not immediately implement the other provisions of SB 2375 (those requiring HQE to place prosecutors onsite at MBC's investigative offices and at its intake unit, which was then being centralized in Sacramento) on a formal basis. For his part, the OAH Director announced in May 1991 his appointment of all 27 OAH ALJs to the new Medical Quality Hearing Panel — thus defeating the specialization purpose of the statute.

In April 1991, the Auditor General released a new report finding that MBC would not be able to comply with the January 1992 deadline for completing investigations within the six-month goal established by SB 2375; in fact, the average MBC investigation took fourteen months. The Auditor General documented an unusually high vacancy rate in MBC's investigator positions and excessive investigative caseloads (27:1 before MBC assigned the 900 backlogged cases to investigators and 29:1 after it assigned them, while investigators at comparable agencies maintained average caseloads of 5–10 cases). Exacerbating the investigative delay, HQE took over 200 days to file an accusation in a fully investigated case ("exceeding its 60-day goal by 233%"); and another 264 days elapsed from the filing of the accusation to the completion of the hearing by the Office of Administrative

Hearings. In sum, DMQ, HQE, and OAH took an average of 2.8 years to process a serious discipline case, from receipt of the complaint to a disciplinary decision (which is then subject to judicial review). The Auditor General also reviewed a sample of cases closed during 1990, and found no basis for the Board's "closed without merit" determination in 17% of the cases sampled; further, another 15% of the "closed without merit" cases had been closed without required supervisory approval. MBC disputed the Auditor General's findings at a May 1991 hearing before the Senate Business and Professions Committee, and summarized its accomplishments over the past year — including its assignment of over 900 backlogged complaints to its investigators.

During the fall of 1991, MBC raised its renewal fees to $400 biennially, and agreed to consider another fee increase to finance additional HQE staff. At the request of Board members, staff began to present an "enforcement matrix" to the Board at its quarterly meetings, to enable the Board to monitor the number of enforcement cases moving through the system, case cycle times, and "case aging data."

However, no new attorneys were added to HQE. By the spring of 1992, HQE attorneys were carrying caseloads of 30 each, and it took them an average of 486 days — well over a year — to file accusations in completed investigations. MBC finally agreed to increase licensing fees to $480 biennially ($240 per year) to finance 22 additional attorneys. At the same time, DMQ rejected the ideas of implementing its citation and fine authority under section 125.9 (which had been in place since 1987) and creating a cost recovery system such as that recommended in *Code Blue*.

D. Continuing Crisis: The CHP Report and SB 916 (Presley)

In June 1992, the DCA Director requested a formal investigation of "[s]erious allegations of misconduct . . . [within MBC, which] may have jeopardized the health, safety and welfare of hundreds of California citizens." Specifically, the Director sought an investigation of allegations by MBC peace officer investigators that widespread "case dumping" was ordered by management at the Medical Board during 1990 to reduce investigative backlogs. In other words, MBC investigators claimed that they had been ordered to close cases rather than investigate them, in order to reduce the investigative backlog documented by LAO. Although other charges of misconduct were alleged, the Director was particularly concerned about the "case dumping" charges because they appeared to be supported by the April 1991 Auditor General report which found a series of unsupported and unreviewed case closures. The California Highway Patrol's (CHP) Bureau of Internal Affairs agreed to undertake the investigation, and MBC employees were ordered to cooperate with the CHP.

Also in June 1992, CBS News' "60 Minutes" aired a segment on MBC's enforcement program entitled *Negligent Doctors*. Reporter Mike Wallace profiled the Board's handling of a number of notorious cases (including Klvana) in which physicians with lengthy and egregious

disciplinary histories had to be criminally charged and jailed before MBC took any action against their licenses. "60 Minutes" took particular aim at MBC's "public disclosure policy," which still precluded the Board from informing consumers that a physician had suffered criminal convictions, medical malpractice judgments and settlements, and loss of hospital privileges — even though those facts were known to the Board. At its July 31 meeting, MBC charged that the segment was biased and distributed a handout which attempted to respond to various issues raised. However, the Wilson administration was embarrassed by the spectacle, and MBC's executive director — beleaguered by the ongoing CHP investigation and the "60 Minutes" exposé — resigned under pressure in November 1992.

The CHP Report. On January 20, 1993, CHP released a report on its investigation of MBC's enforcement program and, specifically, its handling of backlogged complaints during 1990. CHP found that "employees of the MBC dispose[d] of some citizens' complaints in an inappropriate manner." Specifically, CHP found that MBC dispatched a "three-member management team . . . to conduct an audit of various District offices in an effort to determine whether the backlogged cases should be handled by a means other than through investigation . . . . [T]he team directed the closure of approximately 200 to 300 complaints." Because the majority of these complaints were closed "without merit," they had been purged and destroyed, making them unavailable for CHP to review. However, CHP reviewed a number of cases ordered closed "with merit" (which are kept for five years), and found that 80% of them needed further work and/or follow-up before such a decision could have been properly made. According to CHP, "it is important to note that the audit team did not conduct, or direct any District Supervisors to conduct, further investigation and/or follow-up prior to their making a final determination as to the closure of the 200 to 300 complaints. On the contrary, the majority of the Supervisors testified . . . [that] the decisions by the audit team were given and received as direction to close the cases . . ." (emphasis original). Thus, CHP concluded that the MBC management team's directive to MBC peace officers to close almost 300 cases "may have been inappropriate . . . . Finally, instructions provided [by the management team] to the various District Supervisors to not forward closing letters to the complainants of closed investigations was inconsistent with Board policy and procedure."

In addition to the improper closure of the 200 to 300 cases described above, CHP investigated other cases that MBC investigators alleged were inappropriately handled. CHP found at least nine cases — most involving a patient death — that had been "poorly investigated" ("investigations were incomplete, witness statements were missing, and the investigative reports were confusing") and inappropriately closed. CHP also found that MBC had failed to review and appropriately process section 801 and National Practitioner Data Bank reports of civil settlements against physicians. In addition, CHP documented a number of other incidents of misconduct by MBC employees, including numerous hiring and promotion improprieties and misuse of state time, vehicles, telephones, credit cards, and undercover driver's licenses. Finally, CHP reviewed a number

of allegations concerning the Diversion Program and — while it did not make definitive findings — expressed concern that group facilitators characterized as "volunteers" were in fact making up to $7,000 per month for holding two meetings per week; one case manager was not collecting urine samples from participants as frequently as required; some Diversion staff made "threatening" comments to participants; and the Program Manager improperly accepted expensive gifts from participants in the Program.

The findings of the CHP report were widely covered in almost every newspaper in California, and prompted calls for the repeal of MICRA in many quarters, based on the conclusion that the promised balance of medical regulatory reforms had not materialized. In particular, critics argued that if the "enhanced" MBC regulatory system was not working for consumers, then MICRA's benefits to the medical profession and insurance industry should be repealed. Within a month after the release of the CHP report, Senator Presley and CPIL introduced SB 916 (Presley), another comprehensive physician discipline system reform bill. In the meantime, the Board — whose membership was evolving into a majority of Wilson administration appointees — had replaced its executive director and enforcement chief. Prodded by DCA, the Board's new management announced an eight-point plan to address the deficiencies identified in the CHP report. Among other things, MBC promised to reopen six cases that had been improperly closed in 1990, tighten investigative policies and procedures by revising its enforcement manuals, enhance consumer access to MBC by increasing the staffing of its toll-free complaint line, and audit the Diversion Program to determine whether it should remain within MBC or be outsourced to a private entity.

In March 1993, MBC and DCA convened a two-day "Medical Summit" of community, consumer, and medical profession leaders to discuss the many problems of MBC's enforcement program and to develop solutions to those problems. Thereafter, MBC convened a series of task forces to address certain issues raised at the Summit — including the Board's lack of intermediate remedies, its public disclosure policy, the Diversion Program, and medical input into MBC enforcement decisionmaking (that is, the Board's use of medical consultants (physician employees) in its district offices and expert reviewers). The task forces met to take public comment and testimony throughout March and April, and readied recommendations for the Board's May 1993 meeting.

At its May 1993 meeting, MBC adopted the Enforcement Task Force's recommendation that it create several levels of intermediate sanctions, including a public letter of reprimand and a public citation and fine system. Over the objection of CMA, the Board also adopted the Complaint Processing and Information Disclosure Task Force's recommendation to liberalize its public disclosure policy and require disclosure of the following information (if known to the Board): felony convictions, medical malpractice judgments in excess of $30,000, prior discipline in California and in other states, involuntary revocation or restriction of hospital privileges, and completed MBC investigations at point of referral to HQE (instead of delaying public disclosure until the accusation

is actually filed). The Board also voted to seek legislation abolishing the regional MQRCs and its Division of Allied Health Professions, and to redirect DAHP's five members to the Division of Medical Quality, which would then be split into two six-member panels for purposes of reviewing proposed ALJ decisions and expediting the discipline process. These provisions were amended into SB 916 (Presley).

In addition, Senator Presley added a number of other reforms to SB 916 that had been suggested in *Code Blue* but were omitted from SB 2375 or were included in SB 2375 but had not been properly implemented. For example, early versions of SB 916 again called for the transfer of MBC's peace officer investigators to the supervision of the Attorney General's Office — to permanently prevent a repeat of the interference with MBC peace officer investigations documented in the CHP report. As introduced, SB 916 also included provisions limiting the number of ALJs who could be appointed to the Medical Quality Hearing Panel in the Office of Administrative Hearings, eliminating DMQ and superior court review of ALJ disciplinary decisions (in favor of a specialized panel of Court of Appeal justices), requiring HQE to place two prosecutors in charge of MBC's Central Complaint Unit, expanding MBC investigators' access to medical records and establishing a $1,000-per-day fine for failure to comply with a lawful request for medical records, creating a Medical Board Discipline Monitor to investigate the entire MBC enforcement program and make recommendations for reform, and increasing physician licensing fees to $300 per year to enable HQE to hire additional prosecutors.

During the summer of 1993, SB 916 was extensively negotiated and frequently amended. Like AB 1 almost 20 years earlier, SB 916 evolved into a bill containing at least one provision for each of the major parties — MBC, DCA, CMA, CPIL, and the Attorney General's Office. To obtain its desired provision(s), each party had to give up other provisions it wanted, or grudgingly accept provisions it opposed. The parties finally agreed to a version of SB 916 that was enacted by the Legislature and signed by Governor Wilson on October 11, 1993.

SB 916 (Presley). "Presley II," a 59-part bill, made the following significant changes to MBC's enforcement program:

■ To enhance MBC's detection of problem physicians, SB 916 amended section 805 to require hospitals and health care facilities to expedite the filing of reports on adverse peer review actions; added section 364.1 to the Civil Code, which requires medical malpractice plaintiffs to transmit the 90-day intent-to-sue letter required by Civil Code section 364 to the Medical Board at the same time it is sent to the defendant physician; and added section 43.96 to the Civil Code, which requires medical societies, health facilities, government agencies, and others who receive complaints about physicians to "inform the complainant that the Medical Board of California . . . is the only authority in the state that may take disciplinary action against the license of the named licensee, and

. . . provide to the complainant the address and toll-free number of . . . [MBC]." Despite this infusion of new information into MBC, SB 916 did not include the provision expressly requiring the placement of two prosecutors over the Central Complaint Unit; nor did it transfer MBC's investigators to the supervision of HQE to enable creation of a vertical prosecution model.

■ The bill amended section 2225 to enhance MBC investigators' authority to request and receive medical records from physicians under investigation, and added new section 2225.5 to permit the imposition of a $1,000-per-day fine on physicians who refuse to comply with a lawful MBC request for medical records.

■ SB 916 added new section 2233 to authorize the Board to issue, "by stipulation or settlement," a public letter of reprimand in lieu of filing or prosecuting an accusation. The bill specified that a public letter of reprimand must be limited to cases involving minor violations and issued under guidelines established by the Board in regulations.

■ The bill amended Government Code section 11371 to require the OAH Director to appoint no fewer than five and no more than 25% of the ALJs within OAH to the Medical Quality Hearing Panel created in SB 2375. SB 916 also required OAH to publish the decisions of its MQHP, "together with any court decisions reviewing those decisions, or any court decisions relevant to medical quality adjudications," in a quarterly "Medical Discipline Report" to be funded by MBC.

■ SB 916 abolished DAHP and transferred its members to DMQ. The bill also abolished MBC's MQRCs and delegated authority to OAH ALJs to preside over medical discipline evidentiary hearings. New section 2332 authorized DMQ to establish panels or lists of experts to assist it in administering its enforcement program. As did SB 2375, SB 916 preserved the DMQ review step, but amendments to section 2230 required DMQ to divide into two panels for purposes of reviewing proposed ALJ decisions and stipulations.

■ In the area of judicial review, SB 916 eliminated superior court review of DMQ decisions and amended section 2337 to provide that review of a final decision by DMQ shall be by way of a petition for writ of mandate to a court of appeal, which shall exercise its independent judgment in reviewing the administrative proceeding. The effective date of this provision, which also authorized the Judicial Council to adopt rules allocating MBC cases to a particular panel or panels within each district, was delayed until January 1, 1995 (and was further postponed to January 1, 1996 in 1994's SB 1775 (Presley)).

■ The bill codified the Board's new public disclosure policy, requiring MBC to adopt regulations mandating the disclosure of (in addition to its own disciplinary actions) felony convictions, medical malpractice judgments in excess of $30,000, temporary restraining orders and

interim suspension orders, Board-ordered limitations on practice, public letters of reprimand, citations, fines, and disciplinary action taken by medical boards in other states. Before SB 916 was enacted, CMA opposition resulted in the deletion of peer review actions from the public disclosure provision.

■ The "Medical Board Discipline Monitor" proposal was stricken from the bill; instead, new section 116 authorized the DCA Director to audit and review inquiries and complaints regarding MBC licensees at the request of a consumer or licensee. The bill also required the State Auditor (formerly the Auditor General) to audit MBC's discipline system on or before March 1, 1995, including a review and evaluation of services provided to the Board by the Attorney General's Office and documentation of the costs of HQE and OAH.

■ Finally, SB 916 amended section 2435 to authorize MBC to increase its biennial renewal fees from $500 to $600. This fee increase, which DMQ implemented via emergency rulemaking in November 1993, was used primarily to enhance the staffing of HQE so that fully investigated cases did not sit for over one year prior to the filing of the accusation.

In late 1993, the Board's Diversion Task Force — which had been appointed after the Medical Summit to study Diversion-related findings in the CHP report — recommended that the Diversion Program remain within the Medical Board and that several issues raised by the CHP, including the method of payment to group facilitators, should be delegated to the Liaison Committee to the Diversion Program, a joint MBC/CMA committee that meets in private, reviews Diversion-related issues, and makes recommendations to DMQ. The Task Force recommended no substantive changes to the Diversion Program. DMQ disbanded the Task Force.

Consistent with SB 916's addition of the "public letter of reprimand" sanction as a mid-level remedy, MBC finally agreed to implement its citation and fine authority under Business and Professions Code section 125.9 (which had existed since 1987). In early 1994, DMQ adopted citation and fine regulations identifying minor violations of the Business and Professions Code and MBC's regulations which justify the issuance of a citation, an order of abatement, and/or a fine not to exceed $2,500. DMQ also adopted regulations implementing new section 2233's "public letter of reprimand" authority, and codifying the public disclosure policy set forth in SB 916.

Also in 1994, after a 16-month study resulting from the Medical Summit, MBC adopted the recommendation of its Task Force on Medical Quality Review to overhaul the enforcement program's use of medical consultants (MCs) and expert reviewers. The Task Force was confronted with complaints from both investigators and HQE prosecutors that MBC's full-time district office MCs — many of whom were retired from the practice of medicine — did not select the best expert reviewers available in quality of care cases, failed to monitor the progress of expert reviewers and

ensure their opinions were clearly explained and adequately justified, and refused to accept supervision by non-physician district office supervising investigators. Further, HQE prosecutors complained that the Board lacked even minimum qualifications for MCs and for expert reviewers chosen by the MCs, such as active medical practice, recent experience in the relevant specialty, and an absence of malpractice payouts and disciplinary history. After nine public hearings and an extensive study of its current system and alternatives, MBC decided to (1) abolish its full-time Chief Medical Consultant position in favor of a more flexible position entitled "Medical Consultant to the Board" — of which there could be more than one — who would be selected by and report to the Board's Executive Director; (2) abolish its full-time MC positions in favor of hiring "permanent intermittent" physician employees — physicians who would continue to actively practice medicine and maintain board certification, but would also work part-time at MBC under the supervision of district office supervising investigators to advise and provide medical input into the investigative process; and (3) adopt minimum qualifications for expert reviewers, including active practice (or retired for no more than two years), board certification, and at least five years of experience in the specialty at issue in the case being reviewed; a clear license with no prior discipline, no accusation pending, and no complaints closed with merit; and completion of a required MBC expert reviewer training course.

In January 1995, MBC published an article in its *Action Report* newsletter recognizing "a near-crisis" in hospitals' apparent failure to comply with section 805, which requires them to file a report with MBC when they take adverse peer review action against the privileges of physicians for a medical disciplinary cause or reason. Although 249 section 805 reports were filed in 1987–88, the state's 550 hospitals filed only 124 section 805 reports in 1993–94, and many of those were late or incomplete. The drop in 805 reporting was especially disturbing because three recent legislative changes which (1) enhanced the required reporting of peer review action, (2) conferred absolute immunity from civil liability on those required to report, and (3) increased the penalty for failure to report were expected to double the level of section 805 reporting — not halve it. MBC called on health care facilities to rise above the "business considerations" which had already been addressed by the Legislature and enable the Board to carry out its fundamental consumer protection role by complying with the statute.

In March 1995, the State Auditor released its audit of MBC's enforcement program as required by SB 916. Focusing on 1993–94, the Auditor found that MBC received 7,902 complaints (a 17% increase over the prior year), closed 71% of them in the Central Complaint Unit (a 14% increase over the prior year), referred 2,046 for formal investigation (a 7% decrease over the prior year), referred 601 cases to HQE for the filing of an accusation (a 39% increase over the prior year), and took a total of 224 disciplinary actions (a 50% increase over the prior year). The audit noted that because HQE prosecutors were laboring with caseloads of 30 each, backlogs of unfiled cases were growing, and HQE had requested funding to hire additional attorneys. The Auditor noted that

effective January 1, 1993, AB 2743 (Frazee) (Chapter 1289, Statutes of 1992) added section 125.3 to the Business and Professions Code, enabling MBC to create a cost recovery mechanism (such as that recommended in *Code Blue* six years earlier) to recoup some of its investigative and enforcement costs from disciplined licensees. The Auditor found that MBC spent over $25 million on enforcement during 1993–94, could have recovered $6.3 million in cost recovery, but recovered only $94,000 because of its failure to properly implement its cost recovery authority. Specifically, MBC sought reimbursement for only 5.28% of its eligible investigative costs during 1993–94, and failed entirely to request reimbursement for the costs it incurred on medical consultant review and expert review of quality of care cases, the costs of psychiatric competency examinations, or its cost to administer the Diversion Program as against physicians ordered to participate in it as an alternative to disciplinary action or pursuant to a stipulated settlement. The Auditor General urged MBC to recoup more of its investigative and enforcement costs from disciplined licensees.[46]

In May 1995, MBC's enforcement chief — noting a 23% increase in MBC complaint volume during the prior two years with no corresponding increase in investigative staff, excessive caseloads for MBC investigators, and a 10% vacancy rate in investigator positions because trained MBC investigators were leaving the Board for other agencies with higher pay and lower caseloads of lesser complexity — urged DMQ to seek a fee increase to finance more investigators and prosecutors, and lower case cycle times and backlogs. Faced with CMA opposition, the Division rejected that request in May 1995, but (in exchange) instructed staff to implement the cost recovery authority available since 1993, as recommended by the State Auditor.

Upon reconsideration of the enforcement chief's fee increase request in November 1995, and reminded of its public protection priority, the 23% steady increase in complaint volume, the 15-month average investigative timeframe (and a two-year timeframe for the filing of accusations in serious cases warranting discipline), and the medical profession's MICRA promise to support an adequately resourced enforcement program, the full Board voted to seek legislation during 1996 to increase the cap on physician renewal fees to $700 biennially effective January 1, 1997.

During 1996, however, MBC's newly-selected executive director sought and received permission from the Board to delay a fee increase bill until he could get a handle on the Board's budget and attempt to fund new investigators by cutting expenditures in other areas and utilizing unexpected savings. Among other things, a long-anticipated salary increase for MBC employees did not materialize in 1996; MBC was not required to contribute $1 million toward the cost of a new

[46] MBC's cost recovery authority under section 125.3(c) is limited to "investigative and enforcement costs [incurred] up to the date of the hearing . . . ." The Auditor General urged MBC to seek legislation authorizing it to seek reimbursement of fees and costs during the hearing as well. CPIL and CMA opposed this proposal, arguing that such expanded cost recovery would unduly chill the willingness of accused physicians to exercise their right to a public disciplinary hearing. As a result, MBC sought no changes to its cost recovery authority.

Department computer tracking system because the contract fell through; its licensee base was increasing and bringing in unanticipated and unbudgeted revenues; and the Board's implementation of its cost recovery authority was beginning to bear fruit. As such, the executive director expressed a desire to examine the Board's entire budget and wring all possible efficiencies from it before seeking a fee increase. MBC approved his proposal, and eventually decided to wait until its 1997–98 sunset review to seek a fee increase.

• SB 609 (Rosenthal) and AB 103 (Figueroa)

SB 609 (Rosenthal). In the meantime, SB 916's January 1, 1996 implementation date for elimination of superior court review of DMQ decisions was fast approaching. During 1995, MBC, CMA, CPIL, and the Judicial Council negotiated another bill that further revised the procedure for judicial review of DMQ decisions. In September 1995, SB 609 (Rosenthal) — an important bill affecting DMQ review of ALJ recommendations and judicial review of DMQ decisions — was enacted. Instead of eliminating superior court review, the bill revised section 2337 to preserve superior court review but to potentially short-cut appellate review of the superior court's decision in appropriate cases. Specifically, section 2337 provides that appeal of a superior court decision affirming a DMQ disciplinary order must be by way of a petition for extraordinary writ. This mechanism permits the appellate court to reject a nonmeritorious case after full briefing, but without the oral argument and written decision required by a direct appeal.[47] Among other things, SB 609 also amended section 2335 to require DMQ, in reviewing a proposed ALJ decision in a disciplinary proceeding, to give "great weight" to the findings of fact made by the ALJ, and to require DMQ members to attend oral argument and read the entire record before voting to increase the penalty; and added section 2336 to require DMQ to adopt regulations governing the conduct of oral argument after nonadoption of an ALJ decision.

Meanwhile, both HQE and MBC were dissatisfied at the average length of time that a fully investigated case sat at HQE before an accusation was filed. Although this timeframe had dropped from a high of 486 days in 1992 to 274 days in 1994 to 134 days in 1996, the delay in the filing of the accusation means a delay in the point at which the matter becomes public information. In 1996, the two enforcement partners finally decided that HQE had sufficient staffing to formally implement SB 2375's provision (enacted in 1990) requiring the HQE chief to assign attorneys to work onsite at MBC district offices "to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." On January 1, 1997, MBC and HQE launched the "Deputy in District Office" (DIDO) program, whereby a deputy attorney general (DAG) from HQE physically

[47] The constitutionality of section 2337's extraordinary writ requirement was later upheld in *Leone v. Medical Board of California* (2000) 22 Cal. 4th 660.

works in MBC district offices one or two days per week to permit onsite prosecutor guidance of investigations. As announced in 1997, DIDO DAGs were expected to (1) review all new incoming cases, to provide guidance and determine whether MBC should seek an ISO or TRO; (2) become involved in subpoena drafting and enforcement to assist investigators in obtaining requested medical records; (3) review all completed investigations before their referral to HQE, to ensure that all investigative "loose ends" are tied up and the matter is ready for pleading; (4) review all cases proposed for closure at the district office level; and (5) draft the initial pleading in cases being referred to HQE for filing. When DIDO was launched, HQE hoped that accusation filing time would drop from 134 days to about 90 days as a result of earlier prosecutor involvement in investigation design and medical records procurement; however, the results were much more dramatic. After phasing in the DIDO program to all district offices over an 18-month period, HQE was filing accusations within 28 days of case transmittal by July 1, 1998. Despite the apparent success of the DIDO program at the district offices, HQE and MBC still failed to formally implement SB 2375's provision requiring the involvement of prosecutors at the Central Complaint Unit.

AB 103 (Figueroa). During 1997, then-Assemblymember Liz Figueroa tackled MBC's public disclosure policy. She introduced AB 103 (Figueroa) to require MBC to create an Internet Web site and to disclose numerous pieces of information relevant to physician practice. As introduced, AB 103 — which was modeled after the precedent-setting "physician profile" public disclosure policy of the Massachusetts Board of Registration in Medicine — would have required Internet disclosure of the current standing of the licensee; whether the license is subject to an ISO or TRO; whether the licensee has ever been subject to discipline by MBC or another state medical board; all felony convictions reported to the Board after 1993; all cases forwarded to HQE for filing and all current accusations filed by HQE; all medical malpractice judgments, settlements, and arbitration awards; and hospital disciplinary actions that result in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason. Immediate CMA opposition resulted in the deletion of medical malpractice settlements from the disclosure provisions of the bill. However, the rest of the bill remained relatively intact.

As enacted in 1997 and effective January 1, 1998, AB 103 added section 2027 to the Business and Professions Code, and required MBC to post on the Internet information about its licensees' current standing (including ISO/TRO information), prior discipline by the board of another state or jurisdiction, felony convictions reported to the board after 1991, all current accusations filed by the Attorney General, all malpractice judgments and arbitration awards reported to the Board after 1993, and all hospital disciplinary actions resulting in the termination or revocation of a physician's staff privileges for medical disciplinary cause or reason.

• 1997–98 Sunset Review

During the fall of 1997, MBC underwent its first "sunset review" by the Joint Legislative Sunset Review Committee with the following enforcement program statistics. During 1996–97, MBC received 10,123 complaints; it closed 8,161 of them without investigation (80%) and referred 2,039 (20%) for investigation. It referred 567 completed investigations to HQE, and HQE filed 296 accusations or petitions to revoke probation (2%). MBC took 340 disciplinary actions (3%), including 49 revocations, 87 voluntary surrenders, and 112 straight probation orders (with no suspension). CCU's average case cycle time was 64 days (down from 91 in 1994–95) and the average investigative cycle time was 336 days (220 days over the six-month goal established in 1990). At HQE, an average of 134 days elapsed between the time HQE received a completed investigation and the filing of the accusation. The results of a "consumer satisfaction survey" were not favorable. While 43% of respondents were very satisfied with knowing where to file a complaint, their satisfaction level dropped significantly when it came to how well MBC kept them informed about their complaint status (19% very satisfied and 40% very dissatisfied), the time it took to process a complaint (19% very satisfied and 45% very dissatisfied), and the final outcome of the case (10% very satisfied and 75% dissatisfied). Forty-six percent (46%) were very dissatisfied with the Board's overall service, and only 16% were very satisfied.

During its sunset review, MBC stated that, despite various program and procedural improvements and fee increases occasioned by SB 2375 and SB 916, it suffered from an "unreasonably heavy investigator caseload [26 cases per investigator], lack of compliance by physicians in providing patient medical records, lack of compliance with section 805 peer review and other reporting requirements, and outdated, ineffective data processing capabilities with the current computer enforcement tracking system (the Department of Consumer Affairs' CAS system)." MBC sought extension of its existence, a fee increase to support more investigators (as voted by the Board in November 1995), and "single-signature authority" for its executive director to suspend a physician's license in egregious cases (as opposed to the existing interim suspension authority). The JLSRC recognized "a significant increase in the number of complaints filed" with MBC between 1992–93 and 1996–97, but also found that MBC had (since 1994–95) slashed its overall case processing time in most areas and increased its disciplinary output — largely due to the centralization of the complaint intake process and the recent success of the DIDO program in cutting the time it took to file accusations. Although JLSRC staff stressed that MBC's average investigative processing time was 13 months (as opposed to the six-month goal established in SB 2375) and recommended that a fee increase be considered, the Joint Committee declined to approve a fee increase to support additional investigators. The Legislature's 1998 sunset bill for the Medical Board, SB 1981 (Greene), merely extended the existence of the Board through 2003; amended section 2225.5 to make failure to comply with a court order enforcing a subpoena for medical records a misdemeanor; and otherwise failed to substantively address any of MBC's stated problems.

When it became clear that sunset review would not yield the increase it had delayed since 1995, MBC sought the increase in another way — by inserting a provision in SB 1930 (Polanco), a 1998 omnibus fee bill for DCA agencies. The Board sought a $90 biennial increase to finance ten new investigator positions and cut the 13-month average investigative lag time; it also needed additional revenue because employee salaries had been raised after a four-year cap, and a new Department-wide computer system requiring MBC contribution was on the horizon. CMA objected to the proposed fee increase. According to Board members, CMA began its negotiation of the requested fee increase by presenting a 14-point "talking paper" demanding — among other things — a full review of the performance of and costs charged by HQE, the elimination of cost recovery, a redefinition of the "repeated negligent acts" basis for discipline in section 2234, and an alternative to section 805 reporting for physicians who "voluntarily" take a leave of absence from their hospital privileges to check into drug/alcohol treatment programs before it would consider agreeing to a fee increase. When the Board refused to agree to these terms, CMA persuaded Senator Polanco to remove MBC's provision from his omnibus bill.[48] CMA cited "unresolved concerns regarding the costs and efficiency of the Attorney General's office in its representation of the Medical Board in enforcement matters." While conceding that the Attorney General is a required participant in MBC enforcement proceedings and that it is a separate constitutional officer not directly accountable to the Medical Board, CMA refused to agree to a fee increase until the Attorney General provided "quality detailed billing in order for the Board to understand exactly what it purchases as the HQE pursues a case."[49]

At its August 1998 meeting, Board members criticized CMA for its opposition to the bill and resolved to explore all options to conserve money and help consumers help themselves — including abolition of the $800,000-per-year Diversion Program, expanded cost recovery against physicians to recoup MBC's investigative costs, increased fines, a change in the Board's composition to a public member majority, disclosure of all malpractice settlements on the Internet, and raising or repealing MICRA's cap on noneconomic damages in medical malpractice actions. According to one Board member, MBC must "support upward modification of the MICRA cap so that California's citizens would, lacking administrative redress, have greater access to civil redress." The regulatory balance so carefully crafted had not been achieved in practice. The Board vowed to renew its fee increase proposal in the Legislature in 1999.

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[48] The Department of Consumer Affairs had determined that MBC's fee increase proposal had demonstrated the need for the fee increase. However, in California, occupational licensing agencies are generally unable to secure the passage of legislation increasing licensing fees unless the affected trade association "signs off on the board's proposal, providing either endorsement or, at least, tacit agreement." Senate Business and Professions Committee, *Analysis of SB 1930 (Polanco)* (Apr. 21, 1998).

[49] On its Web site, CMA posted its "Top Ten Accomplishments for the First Six Months of 1998," and included the following: "Thwarted attempts by the Medical Board of California to raise each physician's license fee by 15% ($90 bi-annually)."

In addition to blocking the fee increase in SB 1930 (Polanco) in 1998, the medical profession was successful in advocating the enactment of an urgency bill imposing a statute of limitations on MBC accusation filing. AB 2719 (Gallegos) (Chapter 301, Statutes of 1998) requires MBC to file an accusation within three years of its discovery of acts which are the basis of disciplinary charges or within seven years of the acts — whichever occurs first. According to the Board, the statute of limitations law exacerbated MBC's needs for additional investigators; without them, its chances of completing complex medical investigations and filing cases within the defined time period would substantially diminish. Because AB 2719 did not specify whether it was retroactive or prospective only, defense counsel for respondent physicians immediately moved to dismiss dozens of prosecutions pending on the date it was signed on grounds that the statute of limitations had been exceeded — costing MBC thousands of dollars in additional attorneys' fees to successfully defeat those motions.

As promised, MBC sponsored AB 265 (Davis) in 1999, which again called for an increase in the Board's biennial renewal fee to $690. The Board argued that its fees had not been adjusted since 1994, and its investigative staff had not been increased since 1992. Since that time, the Board had experienced a 60% increase in the number of complaints received. In addition, MBC contended that its investigators carry higher caseloads than do investigators at other state agencies — over 30 cases per investigator as of June 30, 1998 — despite the Auditor General's 1991 admonition to the Board to reduce average investigator caseloads to levels existing at comparable law enforcement agencies. According to MBC, this excessive caseload level was causing high attrition and low morale among investigators. MBC promised to use the fee increase to increase efficiency, improve investigation cycle times, and reduce investigator caseloads to a more manageable level of 20 or fewer per investigator. In response, CMA again produced its 14-point "talking paper" and announced it would considering supporting a fee increase only if "a substantial number of our reform proposals are adopted."

Also in 1999, CMA introduced SB 1045 (Murray), a competing bill that would have afforded the Board an unspecified fee increase in exchange for substantial changes in MBC's procedures and disciplinary authority. Among other things, SB 1045 would have deprived MBC's enforcement program of section 805 reports on physicians who take a leave of absence from hospital privileges in order to enter drug/alcohol treatment, and instead "diverted" those reports to the Diversion Program; required MBC's executive director to review any prosecution where the combined investigative/prosecution time exceeds 200 hours; required DMQ investigators to give a *Miranda*-type warning to physicians who are under investigation and are called in for interviews, and limited the circumstances under which such interviews may be tape-recorded; exempted physicians — and only physicians — from the cost recovery mechanism in section 125.3; required DMQ to adopt a list

of priorities to guide its investigations and prosecutions[50]; redefined "repeated negligent acts" to exclude "negligent acts that occur during a single course of treatment . . . unless those acts constitute a pattern of conduct reasonably likely to jeopardize patient safety"; characterized the provision of expert medical testimony as "the practice of medicine" subject to MBC disciplinary action; imposed detailed billing and documentation requirements on HQE; and created a "strike force" in HQE for the purpose of investigating alleged violations of the ban on corporate medicine. Desiring time to negotiate the complexities of the two bills privately, the Attorney General persuaded their authors to convert their bills into two-year bills and delay resolution of MBC's proposed fee increase until 2000.

During late 1999 and early 2000, a working group of representatives from MBC, CMA, HQE, and several legislative committees met privately to attempt a compromise on SB 1045. When those attempts failed, the working group expanded to include representatives of DCA, CPIL, the Consumer Attorneys of California, and other groups. By January 2000, CMA had reduced its 14 demands to five: (1) redefinition of "repeated negligent acts" to preclude discipline for actions "during a single course of treatment" unless the physician's actions constitute "a pattern of conduct likely to jeopardize patient care"; (2) an amendment to section 805 prohibiting hospitals from notifying MBC's enforcement program when a physician takes a leave of absence in order to enter substance abuse treatment; (3) imposition of a mandatory $6,000 cap on cost recovery for physicians; (4) a requirement that MBC adopt regulations codifying enforcement program priorities that mandate "the prioritization of cases involving a serious risk to patient safety for investigation and prosecution"; and (5) a 50% reduction in initial license fees for physicians who are in residency programs. In exchange, CMA offered a $90 biennial fee increase.

The proposal was opposed in one or more of its elements by the other parties. HQE opposed the redefinition of "repeated negligent acts." Although CPIL was willing to entertain a time-limited experimental cap on cost recovery, it opposed the elimination of section 805 reports when physicians leave their hospital privileges to enroll in substance abuse treatment. MBC objected to reduced fees for residents and the proposed cap on cost recovery, arguing that CMA was "giving with one hand and taking with the other." Eventually, DCA, other DCA boards with cost recovery authority, and HQE all opposed any cap on cost recovery — signaling a veto even if the bill were passed. At its July 2000 meeting, the full Board voted to oppose the compromise, deciding that the bill's

[50] SB 1045 stated CMA's investigative and prosecutorial priorities as follows: "(1) sexual misconduct with one or more patients where the physician presents a danger to the public; (2) repeated acts of excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor; (3) fraud involving multiple patients; (4) drug or alcohol abuse by a physician involving death or serious bodily injury to a patient; (5) an extreme departure from the standard of care or gross negligence which results in death or serious bodily injury to one or more patients, such that the physician presents a danger to the public; and (6) incompetence which results in death or serious bodily injury to a patient."

concessions in terms of consumer protection were not worth the increased resources offered by the bill. In fact, MBC determined that the bill — because of its give-and-take nature — would not increase resources for the Board's enforcement program and that the cap on cost recovery might encourage angry respondents and their lawyers to drive up the cost of their proceedings with full knowledge that the Board could not recoup those costs — such that the bill might actually decrease enforcement program resources. Based on the opposition of MBC and DCA (which portended a veto), the authors of SB 1045 and AB 265 dropped their bills.

During the fall of 2000, the Senate Business and Professions Committee held a public hearing on health care facilities' failure to comply with section 805. Although the Legislature had stated that "peer review, fairly conducted, will aid the appropriate state licensing boards in their responsibility to regulate and discipline errant healing arts practitioners,"[51] California's 550+ hospitals filed only 82 section 805 reports in 1998–99 — a record low. The hearing was prompted in part by an August 2000 article in the *San Francisco Chronicle* which described the intentional (and negotiated) refusal of a San Francisco hospital to report internal peer review action against its chief of cardiovascular surgery, whose subsequent practice resulted in extensive patient harms. The Committee received testimony from MBC, which had sounded the alarm about declining section 805 compliance five years earlier. Among other things, MBC proposed an increase in the civil penalty for failure to report from $5,000 to $50,000, "based on the Board's experience that a $5,000 penalty is an inadequate deterrent to nonreporting."

The hearing led to the 2001 enactment of SB 16 (Figueroa) (Chapter 614, Statutes of 2001), which made a number of changes to section 805: (1) it increased the maximum fine for willful failure to file an 805 report to $100,000, and to $50,000 for other failures to file; (2) it specified that willful failure to file an 805 report by a licensed healing arts practitioner may constitute unprofessional conduct; and (3) it authorized MBC and other healing arts agencies to audit, as specified, any peer review body to determine its compliance with its responsibilities to file 805 reports and to establish an electronic notification system for the filing of 805 reports. Finally, the bill added section 805.2, which states the Legislature's intent "to provide for a comprehensive study of the peer review process as it is conducted by peer review bodies . . . in order to evaluate the continuing validity of Section 805 and Sections 809 to 809.8, inclusive, and their relevance to the conduct of peer review in California." The bill required MBC to contract with the Institute of Medical Quality for the performance of the study, set forth a list of eight issues that IMQ must address, and required a written report from IMQ by November 1, 2002. In Governor Davis' signing message, he indicated his expectation that MBC would implement SB 16 within its existing resources.

In January 2001, MBC enforcement staff created two proactive programs to address abuses causing harm to the public. First, it created "Operation Safe Medicine" (OSM), a "strike force"

[51] Bus. & Prof. Code § 809(a)(5); *see also Arnett v. Dal Cielo* (1996) 14 Cal. 4th 4, 12.

consisting of four investigators, a supervising investigator, and an office technician. The purpose of OSM was to address an increase in fraudulent "medical practice" by unlicensed individuals in unregulated clinics in California's immigrant communities, predominantly in southern California. In these communities, health care coverage is scarce; health care needs are not always met by qualified physicians and other licensed health care personnel; and unlicensed, unscrupulous individuals are only too willing to step in to fill the void. By September 2001, OSM had infiltrated two unlicensed clinics and worked with local prosecutors on the filing of felony charges against two unlicensed individuals purporting to provide medical diagnosis and treatment for children. Also in 2001, MBC converted one of its investigative positions to an "Internet Crimes Specialist" to target violations ranging from misleading advertising on Web sites to the prescribing of drugs without a prior good faith examination (as required by California law) to trafficking in narcotics. The Internet Crimes Specialist was directed to monitor online activities to detect violations and gather evidence; conduct investigations and initiate prosecutions against violators; and work with other state, local, and federal jurisdictions involved in similar activities.

At its February 2001 meeting, DMQ entertained a request by CMA to reevaluate its public disclosure policy in light of the emergence of the Internet as a major tool of communication. Specifically, CMA sought nondisclosure of "withdrawn accusations" in cases where MBC files an accusation; the physician agrees to undergo a competency examination, clinical training, or coursework; the physician completes the requirement; and MBC withdraws the accusation. CMA's request prompted a wide-ranging discussion of MBC's public disclosure policy, which had been updated most recently in 1998's AB 103 (Figueroa). Since then, several other states had enacted Massachusetts-style "physician profile" Web sites disclosing numerous categories of information, including malpractice settlements; and the Federation of State Medical Boards had adopted a proposal in April 2000 recognizing "the increasing demand for public access to physician-specific information by state medical boards" and encouraging the disclosure of all substantially related criminal convictions, medical malpractice judgment and settlement information, and all hospital disciplinary actions that are required to be reported to the state medical board. Following further discussion at their July 2001 meetings, DMQ and the full Board agreed to appoint a Public Information Disclosure Committee to reevaluate MBC's public disclosure policy.

On October 23, 2001, Governor Davis — confronted with massive general fund deficits — imposed a hiring freeze on most state agencies, regardless of the source of their funding. Under a hiring freeze, state agencies are prohibited from filling employee positions that become vacant due to resignation or retirement. Thus, despite the fact that MBC is a special-fund agency whose salary savings due to the freeze would not assist the general fund deficit whatsoever, it was required to cease filling all positions that became vacant, including enforcement positions.

G. 2001–02 Sunset Review: SB 1950 (Figueroa)

In December 2001, MBC began its second sunset review with enforcement output data that had declined since its first review. During 2000–01, MBC received almost 11,000 complaints; it closed 7,690 of them without investigation (71%) and referred 2,320 (18.5%) for investigation. It referred 510 completed investigations to HQE, and HQE filed 256 accusations or petitions to revoke probation (2.3%). MBC took 288 disciplinary actions (2.6%), including 39 revocations, 49 voluntary surrenders, and 91 straight probation orders (with no suspension). However, the Board had improved its case processing times. CCU's average case cycle time was 53 days and the average investigative cycle time was 204 days (still 77 days over the six-month goal established in 1990). At HQE, an average of 112 days elapsed between the time HQE received a completed investigation and the filing of the accusation. Investigator caseloads had dropped to an average of 18 cases per investigator. MBC's 2000 "consumer satisfaction survey" results revealed greater satisfaction with the Board's communication efforts; about 80% of respondents stated they were satisfied with the information and assistance provided by MBC staff. However, 57% were not satisfied with the Board's explanation of the outcome of their case, and 65% were not satisfied with the overall service provided by MBC.

In January 2002, MBC's Public Information Disclosure Committee held a daylong hearing to take public comment on proposed changes to the Board's public disclosure policy. Consumer advocates argued that, in addition to the information already disclosed by MBC, it should also post on the Internet all information defined as "public information" under the California Public Records Act (including all accusations), substantially related misdemeanor criminal convictions, completed MBC investigations at point of referral to HQE, medical malpractice judgments that are settled on appeal, medical malpractice settlements, and physician training and board certification information. CMA disagreed with the notion of disclosing accusations — especially where they have been dismissed or withdrawn in exchange for an agreement by a physician which has been satisfied. CMA and the insurance industry also objected to the disclosure of malpractice settlements, citing the fact that physicians and their insurers often agree to settle a case not because the physician has been negligent but because the cost of trying the case will outweigh the settlement amount.

As MBC prepared for its final sunset hearing in the spring of 2002, a wave of media stories criticized its enforcement performance and dramatically changed the tenor and direction of the review. A *San Diego Union-Tribune* article described several high-profile medical malpractice judgments — disclosable under MBC's policy — which were quickly appealed and then settled, leading MBC to characterize them as nondisclosable "settlements" and refuse to disclose them. Similarly, a *San Francisco Chronicle* article faulted the Board for its refusal to disclose malpractice judgments settled on appeal, malpractice settlements (even multiple settlements), and criminal convictions — and for leading consumers to believe doctors have "clean records" despite the existence of these events.

But the most damaging series was published in the *Orange County Register* in April 2002 just prior to MBC's final sunset hearing. The series, entitled "Doctors Without Discipline," was disturbingly reminiscent of the *Los Angeles Times*' coverage of the Klvana case twelve years earlier, in that it focused primarily on MBC's handling of one obstetrician who had botched deliveries and injured or killed infants. Indeed, the series illuminated a lengthy eight-year delay between the Board's 1993 receipt of a section 805 report on the physician and its 2001 filing of an accusation against the physician (during which time a child died at the hands of the same physician); MBC's failure to seek an interim suspension order against the physician until 2002, despite multiple complaints, investigations, lawsuits, section 805 reports, and patient deaths; the Board's declining enforcement output ("the Board investigates about 20% of the 10,600 complaints it receives on average every year . . . . About 3 percent lead to formal charges against physicians, and about 1 percent result in doctors losing their licenses"); its failure to check court files for the filing and outcome of medical malpractice actions; its "mandatory" reporting statutes that were easily evaded by physicians (and their lawyers) who wished to avoid being reported to MBC; and its loopholed public disclosure policy that failed to enable patients to protect themselves and their families from dangerous doctors. The series also documented a number of other external failures that exacerbated the flaws in MBC's system, including inadequate reporting of serious physician misconduct to the Medical Board by hospitals, courts, and insurance companies.

The publication of the *Register* series caused the Joint Legislative Sunset Review Committee to postpone MBC's sunset hearing, and to conduct an in-depth investigation into the mechanics of its enforcement program. JLSRC staff drafted a series of 115 questions about the intricacies of the Board's enforcement program, required MBC to answer them in an expedited fashion, examined all of its policy and procedure manuals, and rescheduled the hearing on MBC's sunset review for May 1, 2002.

In the meantime, MBC convened a special meeting on April 24, 2002 to discuss the case featured in the *Register* and to review a revamped public disclosure policy that had been drafted by its Public Information Disclosure Committee. Under the draft policy, MBC would disclose (in addition to all items currently disclosed) any public document filed against any physician and the disposition thereof; all malpractice settlements over $150,000, and three or more settlements within a ten-year period that are between $30,000–$150,000; substantially related misdemeanor convictions; completed investigations that have been referred to HQE for the filing of an accusation; any other public information that is in the possession of the Board that may have an adverse impact on the safe delivery of medical care by a physician (for example, the fact that a physician is required to register as a sex offender); and each licensee's specialty, postgraduate training, and gender. DMQ placed the draft policy on the agenda for its May 2002 meeting.

On May 1, 2002, the JLSRC convened and reviewed a background briefing on the results of its staff's review of MBC responses to the 115 questions and its enforcement procedure manuals.

The background paper featured several findings: (1) every category of Board enforcement activity declined since its last sunset review, even as complaints from patients increased; (2) few complaints become the basis of a formal investigation, few investigations lead to an accusation, and few accusations result in administrative hearings; (3) 65% of complainants are dissatisfied with the results of their complaint to the Board; (4) internal Board practices require the routine closure of most quality of care patient complaints because they fail to satisfy the "gross negligence" basis for discipline — closures that are accomplished without routine consultation with a specialist in the same field or HQE, as required by SB 2375 (Presley), and without a comprehensive review for whether they may constitute "repeated negligent acts" or "incompetence"; (5) the Board does not receive all the information to which it is legally entitled — information that is essential to its enforcement program; (6) MBC's complaint and investigation priorities are questionable; (7) the Board's procedure manuals indicate internal confusion about governing legal standards; and (8) the Board's public disclosure policy misleads the public by failing to disclose malpractice settlements and misdemeanor criminal convictions — information deemed essential to every other medical stakeholder's evaluation of whether to associate with a physician.

The JLSRC heard testimony from some of the victims of the physician featured in the *Register*, and then invited public comment. Consumer advocates renewed their call for an independent "enforcement monitor" (as proposed nine years earlier in SB 916) to examine the entirety of MBC's enforcement program and make recommendations for reform, closure of the loopholes in MBC's mandatory reporting scheme that permits physicians and their employers to evade reporting to the Board, and immediate liberalization of MBC's public disclosure policy to allow consumers to learn the very same information available to the Medical Board before it licenses physicians, medical malpractice carriers before they insure physicians, and hospitals before they grant privileges to physicians. MBC representatives expressed support for the enforcement monitor concept, an improved and expedited complaint handling process, clarification of the Board's mandatory reporting statutes, and an enhanced public disclosure policy. The Department of Consumer Affairs agreed to the appointment of an independent enforcement monitor. CMA reminded the JLSRC that it had previously supported the creation of HQE, the specialized panel of ALJs in OAH, interim suspension authority for the ALJs, and the study of peer review authorized in 2001's SB 16 (Figueroa). However, CMA opposed the disclosure of "unanalyzed, ambiguous information" that would not be helpful to consumers — specifically, complaint and settlement information. CMA argued that public disclosure is no substitute for discipline; if a physician is truly dangerous, MBC should take disciplinary action against that physician and publicize that action. The insurance industry also objected to the disclosure of any malpractice settlement information on grounds that such disclosure would discourage specialists to take on high-risk patients, delay the settlement process and compensation to injured victims, and lead to a 10% increase in medical malpractice premiums.

At the conclusion of the May 1 hearing, the JLSRC voted to support five "work in progress" recommendations for inclusion in SB 1950 (Figueroa), MBC's sunset legislation: (1) the Department Director should appoint an independent enforcement monitor to evaluate MBC's enforcement program and report its findings and recommendations to the Legislature and Department; (2) MBC should continue to assess and improve its consumer satisfaction ratings of its complaint handling; (3) MBC's public disclosure policy should be amended to require the disclosure of all substantially related criminal convictions against physicians, malpractice settlements over $30,000, current specialty and completed postgraduate training, and completed investigations that have been referred to HQE; further, the JLSRC recommended that insurers be fined for failure to report malpractice judgments and settlements to MBC, plaintiffs' attorneys should file a copy of malpractice actions with MBC (and MBC should treat such filing as a complaint), all judgments should be reported to and disclosed by MBC (regardless of whether they are settled on appeal), and judgments and settlements entered against medical corporations controlled by a physician whose actions led to the judgment or settlement should be reported to MBC; (4) two more public members should be added to the Medical Board; and (5) the Board — with a revamped composition as described above — should continue to regulate the medical profession in California until the JLSRC and the Department can review the enforcement monitor's findings and recommendations.

At its May 2002 meeting, the Public Information Disclosure Committee, DMQ, and the full Board debated the draft public disclosure policy first unveiled on April 24. After receiving input from CMA, CPIL, and the insurance industry, the Committee — and later DMQ and the full Board — voted to seek legislation requiring MBC disclosure of all medical malpractice settlements over $30,000; all misdemeanor criminal convictions that are substantially related to the duties, qualifications, and functions of a physician; and completed investigations at point of referral to HQE. With regard to malpractice settlements, MBC agreed to accompany their disclosure with disclaimers and "contextual" information about whether the specialty is one in which physicians are statistically sued frequently and whether the amount is high, low, or average for that specialty. These provisions were amended into the May 20, 2002 version of SB 1950.

During the summer of 2002, representatives of MBC, DCA, HQE, CPIL, CMA, and the insurance industry negotiated the terms of SB 1950 with the staff of Senator Figueroa and other legislators. The product was much like AB 1 (Keene) and SB 916 (Presley) — a bill containing at least one provision that each stakeholder wanted, and others that each opposed.

SB 1950 (Figueroa). On September 29, 2002, Governor Davis signed SB 1950 (Figueroa) (Chapter 1085, Statutes of 2002), which attempted to address the flaws in MBC's enforcement program illustrated in the media reports and MBC's sunset review. Many of the major provisions of SB 1950 are discussed in detail elsewhere in this report; however, following is a list of some of the more significant changes made by the bill:

■ SB 1950 added section 2220.1, which creates an independent "enforcement monitor" appointed by the DCA Director and charged with reviewing the entire MBC enforcement program and its Diversion Program for a two-year period.

■ The bill extended the Medical Board's existence until the findings and recommendations of the enforcement monitor can be evaluated. However, it also changed MBC's composition by adding two public members to DMQ, thus converting MBC into a 21-member board consisting of twelve physicians and nine public members. DOL consists of seven members (four physicians and three public members) and DMQ now consists of fourteen members (eight physicians and six public members). For purposes of reviewing ALJ decisions, DMQ divides into two panels each consisting of seven members (four physicians and three public members).

■ SB 1950 added section 2220.05, which sets forth a list of five types of "priority cases" whose processing, investigation, and prosecution should be expedited by MBC and HQE. The provision directs MBC to "ensure that its resources are maximized for the protection of the public" by identifying and expediting the processing of certain types of matters "representing the greatest threat of harm." The new section also requires MBC to identify, in its annual report, the number of disciplinary actions, TROs, and ISOs taken in each "priority" category.

■ The bill also added section 2220.08, which sets forth a new case procedure for the processing of quality of care complaints by the Central Complaint Unit. Before any quality of care complaint is referred to an MBC field office for investigation, it must be reviewed by "one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." That evaluation must include the review of relevant patient records, a statement or explanation of the care and treatment provided by the complained-of physician, expert testimony or literature provided by the complained-of physician, and any additional information requested by the expert reviewer that may assist him or her in determining whether the care rendered constitutes a departure from the standard of care.

■ SB 1950 closed loopholes in the Board's mandatory reporting statutes by clarifying that a medical malpractice judgment in any amount must be reported to MBC "whether or not vacated by a settlement after entry of the judgment, that was not reversed on appeal . . . ." It also required the reporting of settlements over $30,000 "if the settlement is based on the licensee's negligence, error, or omission in practice, or by the licensee's rendering of unauthorized professional services, and a party to the settlement is a corporation, medical group, partnership, or other corporate entity in which the licensee has an ownership interest or that employs or contracts with the licensee."

■ The bill amended section 803.1 to authorize the Board to disclose information about some civil malpractice settlements. The Board must categorize each medical specialty as "high-risk" or

"low-risk." If a physician in a "high-risk" specialty enters into four malpractice settlements in a ten-year period, they will be disclosed for ten years; if a physician in a "low-risk" specialty enters into three malpractice settlements in a ten-year period, they will be disclosed for ten years. The Board may not disclose the actual dollar amount of the settlement; when it is authorized to disclose the settlements of a particular physician, it must disclose the total number of physicians in that specialty, the number of those physicians in that specialty who have entered into a settlement agreement in the prior ten-year period, whether the amounts of the settlements being disclosed are above average, average, or below average for the most recent ten-year period, and the number of years the licensee has practiced in that specialty. Any disclosure of settlement information must be accompanied by a lengthy disclaimer included in the statute. SB 1950 also required MBC to disclose its licensees' specialty and approved postgraduate training. Finally, SB 1950 prohibited the Board from disclosing on the Internet accusations that have been "dismissed, withdrawn, or settled," and limited MBC's Internet disclosure of all categories of information except section 805 reports and felony convictions to a ten-year period.

■ SB 1950 amended section 2234(c) to redefine the basis for discipline known as "repeated negligent acts."

■ The bill amended section 2246 to require an ALJ who finds that a physician has engaged in multiple acts of sexual exploitation to include a proposed order of revocation.

■ SB 1950 amended section 2350 to add "mental illness" as a basis for "diversion" from enforcement and participation in the Diversion Program.

■ The bill amended section 2435 to authorize MBC to increase its biennial renewal fees to $610 — in other words, SB 1950 allowed MBC to increase its fees by $5 per year.

In September 2002, as a result of the continuing hiring freeze and budget control language included in the 2002–03 budget bill, MBC lost 15.5 staff positions — including eight enforcement positions. The hiring freeze continued throughout 2002–03 and 2003–04, and MBC was not authorized to fill most positions that became vacant. As a result of the 2002–03 and 2003–04 budget bills and an additional 12% budget reduction imposed during 2003, MBC lost a total of 44.8 staff positions — including 29 enforcement positions. MBC's field investigations staff was reduced from 90 in 2000–01 to 71 by June 30, 2004 — a 25% loss. MBC was forced to disband Operation Safe Medicine and to move its Internet Crimes Specialist back to field investigations. Since the hiring freeze began in October 2001, HQE lost a total of six prosecutor positions — all in its Los Angeles office; in addition, two Los Angeles HQE deputies are out on extended medical leaves.

On August 25, 2003, the DCA Director appointed Julianne D'Angelo Fellmeth of CPIL as the Medical Board Enforcement Monitor.

On October 1, 2003, MBC and HQE formally implemented the provision of CPIL's SB 2375 (Presley) (enacted in 1990) requiring a deputy attorney general to work onsite at the Central Complaint Unit to "assist [DMQ] in intake . . . . Attorneys shall be assigned to work closely with each major intake . . . unit . . . , to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." HQE assigned an attorney to work half-time at CCU, and MBC assigned a supervising investigator to work full-time at CCU.

On October 22, 2003, the MBC Enforcement Monitor began work on this project.

H. Conclusion: Fulfilling the Promise of Balanced Reform

A generation has elapsed since the landmark Medical Injury Compensation Reform Act of 1975 first articulated the promise of balanced medical regulatory reform for California. Realizing that all interested parties, including physicians, lawyers, insurance companies, and patients, "must sacrifice in order to reach a fair and rational solution" to the perceived crisis, Assemblymember Keene designed AB 1 to achieve a delicate balance of tort reform, insurance regulation, and improved medical quality control.[52]

The necessary connection between these policy goals is obvious and important: Relief for physicians and insurers — including unprecedented limits on punitive damages and other major reforms to the tort and insurance process — was inextricably linked to improved protection for the public in the form of a more effective physician discipline system. That linkage is undisputably sound. Reform fair to all parties means that the reduced disciplining effect of the tort sanctions must be balanced by the enhanced disciplining mechanism of the Medical Board.

This beneficial balance, so carefully crafted in AB 1 and its progeny, offered and still offers the promise of improving the future of medicine in California for all parties. But the long series of critiques, studies, and attempted legislative solutions reviewed here indicates that the disciplinary effectiveness portion of the reform program has consistently lagged. As we will see, there is further work to be done to fulfill the 30-year promise of balanced reform.

[52] See Keene, *California's Malpractice Crisis*, *supra* note 41, at 30.